Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2117AGZ	A. BUILDING _____ B. WING _____	01/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT THE SEASONS	5165 SUMMIT RIDGE CT RENO, NV 89523

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Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 1/18/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 120 Residential Facility for Group beds, Category II: 79 for elderly and disabled persons, 11 beds which provide assisted living services and 30 beds for persons with Alzheimer's disease. The census at the time of the survey was 58. Fifteen resident files were reviewed and 15 employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of B. The following deficiencies were identified:	Y 000	POC approved 2-4-11 CD This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors. The facility desires that this plan of correction be considered the facility's allegation of compliance. **Y105 449.200(1)(f) Personnel File-Background Check** **I. CORRECTIVE ACTIONS** Executive Director will ensure that all employees will have a background check as directed by regulation. **II. HOW TO IDENTIFY OTHER STAFF** Executive Director has created a spreadsheet to track required personnel documentation. **III. SYSTEMIC CHANGES** Executive Director has created a spreadsheet to track required personnel documentation. Executive Director and Business Office Director will have ongoing meetings to monitor compliance. **IV. MONITORING PROCESS** This process will be monitored by the Executive Director by conducting on-going random review of employee files to monitor continued compliance. **V. DATE COMPLETION** This plan of correction will be completed by 2/4/2011.	
Y 105 SS=D	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by:	Y 105		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Catherine P. Lenn / Administrator TITLE (X6) DATE 2/2/11

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Y 105	Continued From page 1 Based on record review on 1/18/11, the facility failed to ensure 1 of 15 employees met background check requirements of NRS 449.176 to 449.188 (Employee #12). Severity: 2 Scope: 1	Y 105	**Y255 449.217(6)(a)(b) Permits-Comply is NAC 446 on Food Service** OK W 2/4/10 **VI. CORRECTIVE ACTIONS** 1. Dining Service Director removed packed of ready to eat light tuna fish. Completed 1-18-2011. 2. Cleaning and Sanitation Issues: a. ziplock baggy was removed on 1-18-2011 b. Ice scoop was sanitized and properly stored with direction to staff on proper storage on 1-18-2011. c. The deli slicer blade was put on the kitchen cleaning schedule as well as cleaning on 1-18-2011. The white cutting boards were cleaned on 1-18-2011 and scheduled to be replaced no later than 2-4-2011. The rim around the ice machine was cleaned on 1-18-2011 and placed on the routine cleaning schedule. d. The shelving units above the food preparation were cleaned on 1-19-2011 and placed on our routine cleaning schedule. The dish carts in the dry storage were cleaned on 1-18-2011 and placed on the routine schedule for cleaning. e. The floor sink for the dishwashing machine had the drain pipe replaced on 1-19-2011 and bids for floor repair are being gathered with floor repair to be approved no later than 2-28-2011. f. Kitchen handwashing sink was repaired on 1-19-2011 and placed on cleaning schedule to be monitored for any new issues. g. Air vents, ceiling tiles, and wall junctures were cleaned on 1-19-2011 and placed on routine cleaning schedule for regular cleaning.	
Y 255 SS=F	449.217(6)(a)(b) Permits - Comply with NAC 446 on Food Service NAC 449.217 6. A residential facility with more than 10 residents must: (a) Comply with the standards prescribed in chapter 446 of NAC. (b) Obtain the necessary permits from the Bureau of Health Protection Services of the Division. This Regulation is not met as evidenced by: Based on observation, interview and record review on 1/18/11, the facility failed to ensure the kitchen complied with the standards of NAC 446. Findings include: 1 Critical Violations: a. A package of ready-to-eat light tuna fish was found spoiled in the dry storage room. A tear in the package exposed the tuna fish to room	Y 255		

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Y 255	Continued From page 2 temperature for approximately six days. 2. Cleaning and Sanitation Issues: a. A 'ziplock baggy' of cooked chicken was not properly labeled in the walk-in refrigerator. b. The ice scoop was not properly stored. c. The following food contact surfaces were soiled with food and kitchen debris: the deli slicer blade sharpening area, multiple white cutting boards, and the rim around the ice machine where the door seals. d. The following non-food contact surfaces were soiled with food, dust, and kitchen debris: the shelving units above the food preparation table in the back of the kitchen and the food/dish carts located in the dry storage room. e. The floor sink for the dishwashing machine was not properly draining because of the drain pipe placement. f. A kitchen handwashing sink, located near the walk-in refrigerator, was not properly draining. g. Multiple air vents, ceiling tiles, and wall junctures were soiled with dust, dirt, and debris throughout the kitchen and dry storage room. Severity 2: Scope: 3	Y 255	**VII. HOW TO IDENTIFY OTHER RESIDENTS** Dining Services Director will monitor on-going cleanliness in kitchen with random audits to be completed by Executive Director. **VIII. SYSTEMIC CHANGES** Routine cleaning schedule has been updated to reflect areas of interest with kitchen staff utilizing daily and weekly cleaning scheduled. **IX. MONITORING PROCESS** Dining Services Director will do random audits of cleaning schedules to ensure staff compliance with random audits done by Executive Director. **X. DATE COMPLETION** Items listed above reflect completion of 1-19-2011 with large floor repair to be approved no later than 2-28-2011. **Y878 449.2742 (6) (a) (1)Medication/Change Order** **XI. CORRECTIVE ACTIONS** The resident receiving the Ester-C at the higher dosage had the physician contacted to inform them of the issue. Immediately the correct dosage was being given and resident was being monitored for any adverse reactions.. **XII. HOW TO IDENTIFY OTHER RESIDENTS** Physician orders for residents will be reviewed by the Resident Care Director or designee for accuracy when transferred to MAR to ensure that each resident medication physician orders are implemented as prescribed. Random MAR audits will be conducted by Resident Care Director or designee to ensure that all medications match the MAR and are being given as prescribed. . **XIII. SYSTEMIC CHANGES** MAR checks are being done by facility staff on a regular basis to ensure compliance with MAR. Resident Care Director or Wellness Coordinator to do regular medication cart audits to ensure that medications match the MAR and are being given as directed by physician. Executive Director to review	
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this	Y 878		

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Y 878	Continued From page 3 subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review and interview on 1/18/11, the facility failed to ensure that 1 of 15 residents (Resident #1) received medications as prescribed. There was a physician's order to give Ester-C 500 milligrams daily. The medication that had been administered was Ester-C 1000 milligrams daily. This was a repeat deficiency from the State Licensure surveys conducted on 1/9/09 and 1/19/10. Severity: 2 Scope: 1	Y 878	results of audit randomly to ensure continued compliance. **XIV. MONITORING PROCESS** Wellness Coordinator will assist in the MAR checks to ensure items are being completed with oversight from the Resident Care Director reviewing the audits of the mediation cart review on a regular basis. Executive Director will monitor compliance on a regular basis and meet with Resident Care Director frequently to ensure compliance. **XV. DATE COMPLETION** This plan of correction will be completed by 1-31-2011. **Y1035 449.2768 (1)(a)(1) Dementia Training** **I. CORRECTIVE ACTIONS** Staff members #4,6, and 10 received initial dementia training in the amount of 3 hours with documentation placed in their employee file. **II. HOW TO IDENTIFY OTHER STAFF** Executive Director has created a spreadsheet to track required personnel documentation with Business Office Director doing audits to ensure compliance. **III. SYSTEMIC CHANGES** All staff employed by the facility will go through initial dementia related training in the amount of 3 hours prior to being scheduled to work directly with the residents and within the first 40 hours of employement.. **IV. MONITORING PROCESS** Executive Director has created a spreadsheet to track required personnel documentation with Business office Director doing random audits to ensure compliance. Memory Care Director and Resident Care Director will ensure that all employees have received training prior to scheduling them to work directly with residents. **V. DATE COMPLETION** Staff identified received training no later than 1-21-2011 with ongoing monitoring implemented by 2-4-2011.	
Y1035 SS=D	449.2768(1)(a)(1) Dementia Training 449.2768 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes:	Y1035		

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Y1035	Continued From page 4 (1) Within the first 40 hours that such an employee works at the facility after he is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer's disease, and providing support for the members of the resident's family. This Regulation is not met as evidenced by: Based on record review on 1/18/11, the facility failed to ensure that a minimum of 2 hours of training related to the care of persons with dementia was received within the first 40 hours of work by 3 of 15 employees (Employees #4, #6 and #10). Severity: 2 Scope: 1	Y1035	**Y1036 449.2768(1)(a)(2)- Dementia Training** **I. CORRECTIVE ACTIONS** Staff members #4,6, and 10 received additional dementia training in the amount of 8 hours with documentation placed in their employee file. Executive Director will work with Memory Care Director and Resident Care Director to ensure that any staff working with residents diagnosed with dementia not to be scheduled in Memory Care until such training has been completed. **II. HOW TO IDENTIFY OTHER STAFF** Executive Director has created a spreadsheet to track required personnel documentation with Business Office Director doing audits to ensure compliance. **VI. SYSTEMIC CHANGES** Memory Care Director and Resident Care Director will work together to ensure that training in the amount of 8 hours will be completed within first 90 days or hire. Executive Director will do random audits of spreadsheet to ensure training has been done with assistance for the Business Office Director. **IV. MONITORING PROCESS** Memory Care Director and Resident Care Director will work together to ensure that training has been completed within appropriate time with Executive Director doing random audits of spreadsheet to ensure compliance with training with assistance from the Business Office Director. **VII. DATE COMPLETION** Staff identified received training no later than 1-31-2011 with ongoing monitoring implemented by 2-4-2011.	
Y1036 SS=D	449.2768(1)(a)(2) Dementia Training 449.2768 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of training in providing care to a resident with any form of dementia,	Y1036		

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Y1036	Continued From page 5 including, without limitation, Alzheimer's disease. This Regulation is not met as evidenced by: Based on record review on 1/18/11, the facility failed to ensure that a minimum of 8 hours of training related to the care of residents diagnosed with Alzheimer's was received within 90 days of hire by 3 of 15 caregivers (Employee #4, #6 and #10). This was a repeat deficiency from the 1/19/10 State Licensure survey. Severity: 2 Scope: 1	Y1036		